Complaint No.

COMPLAINT FORM
KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

Person Filing Complaint

Name _____

Address _____ City_____ State _____ Zip

Day Telephone (___) _____ Night Telephone (____) _____

Patient's Date of Birth ____ / _____ / _____

Patient Information (if different from above)

Name _____

Address _____ City_____ State _____ Zip

Relation _____

Name of Chiropractor who performed services

Name _____

Address _____ City_____ State _____ Zip

Telephone (____) _____

Names and phone numbers of persons who may provide additional information.

_____
_____
_____
_____
_____

Brief description of offense, include date, time and location

_____

_____

_____

_____

Continue on next page

Brief description of offense (continued)

By signing this complaint form, I hereby certify that the information provided is complete and true to the best of my knowledge.

Signature Date
(patient or guardian)

Send to:
Kentucky Board of Chiropractic Examiners
P.O. Box 1360
Frankfort, KY 40602

KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

P.O. BOX 1360
Frankfort, Kentucky 40602
Phone (502) 564-3296 Fax (502) 564-4818
e-mail <kbce@ky.gov>

Authorization for Release of Medical and Chiropractic Records to the Kentucky Board of Chiropractic Examiners

I, _____ , the undersigned, hereby authorize the full release of any and
Print full name of patient

all medical records, billing information and medical reports from the chiropractor, physician, or other medical personnel, or any licensed health care facility regarding the medical history, diagnosis and treatment relevant to my initiating complaint, filed against _____ ,
Name of treating Chiropractor

to the Kentucky Board of Chiropractic Examiners, or any authorized agent or investigator of the Board. The Board's address is: P.O. Box 1360, Frankfort, KY 40602. Copies of such documents may be mailed to the Board at this address or hand-delivered to any authorized agent or investigator of the Board. A photocopy of this authorization shall be deemed as effective as an original. This authorization shall be effective for one year from the date of signing.

_____ _____

Date Signature of patient or legal guardian of patient